To ID or not to ID:

Who are my patients and what am I doing to them?

Michael G. Lloyd, MBA, CPCU, ARM, CPHRM
Manager, Patient safety, risk and compliance
Providence Health and Services

PROVIDENCE
Health & Services

About the speaker

- Michael Lloyd has been working in healthcare risk/quality/malpractice claims/patient safety since 1983
- He is board certified in insurance, risk management and healthcare risk management
- His clinical experience includes EMS and oncology research

PROVIDENCE
Health & Services

This is how a risk manager rides a motorcycle

This is how a risk manager gets off the ferry on his bicycle

Our presentation agenda

- The role of patient identification in patient safety
- Types of errors
- Liability issues
- Prevention ideas
- Future developments

PROVIDENCE
Health & Services

This is important stuff

- Patient identification has been given a very high priority by regulatory, accreditation and disciplinary agencies
- Problems in identification is the root cause of many errors
- Patient identification is the very first National Patient Safety Goal by the Joint Commission

PROVIDENCE
Health & Services

JC NPSG 01.01.01

- Use at least two patient identifiers when providing care, treatment and services
- Rationale
  - Wrong patient errors occur in virtually all stages of diagnosis and treatment. The intent for this goal is two-fold: to reliably identify the individual receiving treatment and then to match the treatment to that individual

PROVIDENCE
Health & Services

The patient ID process

- Policy and procedure
- Patient admission
- Choice of patient identifiers
- Checking patient identifiers before treatment
- Involving patients in the process
- Rooting out and addressing workarounds and short cuts

PROVIDENCE
Health & Services

Patient admission

- It starts at the moment of admission into the system
- If incorrect identification is entered from the beginning, the chance of error goes up
- How is patient identity confirmed?
- How do you handle patients who cannot give information?

PROVIDENCE
Health & Services

Which identifiers to use?

- Full name
  - Surname, given name and initial
- Date of birth
- Identifying number
  - Medical record number
  - Social security number
- Address
- Other

Checking identifiers

- How do you check identifiers?
- Do you look at a wristband?
- Is a barcode reader used?
- Does the wristband have a photo of the patient on it?
- How do you confirm identifiers verbally with the patient?
- Problem situations

PROVIDENCE
Health & Services

Involving patients

- One of the biggest mistakes in involving patients is rattling off the identifiers to them and asking them to confirm
- A lot of people will say ‘yes’ even if they did not hear or understand you
- It is better to ask the patient to tell you the name, DOB, address or other identifiers

PROVIDENCE
Health & Services

Things to look for

- Work-arounds to existing systems
- Short-cuts
- What can near misses tell you?
- Check for vulnerablilties
- Ask the staff to tell you how they do identification and why they don't follow the process
- Ask for their help in process redesign

PROVIDENCE
Health & Services

Where do ID errors happen?

- Drug administration
- Surgical/therapeutic procedures
- Phlebotomy
- Blood transfusions
- Lab
- Pathology

Why med admin ID errors occur

- Inaccurate wristbands
- Missing wristbands
- Not using at least two identifiers
- Asking the patient to confirm identifying information rather than asking them to tell you information
- Language proficiency or A&O status

continued

Why med admin ID errors occur

- Not checking identifiers against med order or MAR
- Interruptions during medication administration
- Same or similar patient names
- Multiple patients in the same treatment setting

Why lab ID errors occur

- Inaccurate wristbands
- Missing wristbands
- Not using at least two identifiers
- Labeling specimens away from the point of care or bedside
- Using multiple pre-printed labels and attaching one to the wrong specimen
- Batching of specimens

PROVIDENCE
Health & Services

Why surgery ID errors occur

- Incorrect surgery schedule
- Inaccurate clinical notes, op permits or consent forms
- Inaccurate labeling of imaging
- Room setup
- 'X' used as a site marker
- Inability to mark the site
- Site markers washed off during prep

Wrong site surgery by specialty

- 41 % orthopedics
- 20 % general surgery
- 14 % neurosurgery
- 11 % urology
- 14 % all others

Joint Commission data

PROVIDENCE
Health & Services

Types of wrong site errors

- 76 % on wrong body part or site
- 13 % on wrong patient
- 11 % incorrect surgical procedure on the correct patient

- An estimated 1300-2700 cases of wrong-site surgery occur every year in the USA.

Joint Commission data

PROVIDENCE
Health & Services

Most common wrong site

- Knee (left vs. right)
- Spine (spinal level)
- Chest (left vs. right)
- Foot or ankle (left vs. right)
- Hand or wrist (left vs. right)
- Cranium (left vs. right)

Joint Commission data

Universal Protocol?

- I thought the Universal Protocol was going to fix all this?
- Joint Commission data shows that the mandatory ‘time-out’, the final step in the Protocol, is usually not done
- If this final step was done, wrong-site surgery cases should be rare

Liability issues

- Patient identification issues are usually ‘res ipsa’ cases
- Especially in surgery cases, there is enough blame to go around
- Finger-pointing between the various providers and their insurance companies can be a problem
- Most of these cases are candidates for early settlements

PROVIDENCE
Health & Services

Liability issues

- CMS and many private insurers will not pay for wrong site surgery
- There have been several cases involving unnecessary single or double mastectomies due to mislabeling or mixing up the biopsy specimens. Most of these cases settle for the high six or low seven figures

Liability issues

- The most expensive cases are pathology specimen mix-ups and wrong-site surgery cases
- False-positive cases in which something gets removed or amputated are especially costly
- Not to mention the media attention that can accompany these cases

Liability issues

- Several lawsuits involving job losses when drug test samples were mixed up and erroneously reported as positive
- State licensing/disciplinary and professional societies are more frequently imposing sanctions on providers involved in these cases

General prevention tips

- Accurate wristbands
- Checking wristbands
- Use at least two identifiers
- Have the patients tell you their identifiers rather than asking them to confirm their identifiers
- Standardize the process
- Eliminate workarounds/shortcuts

PROVIDENCE
Health & Services

General prevention tips

- Have a protocol for identifying patients who lack identification
- Encourage patient participation
- Have protocols for questioning orders (labs, meds and procedures) when they are inconsistent with the patient's clinical history
- Call your risk manager if a patient identification error happens

Preventing wrong site surgery

- JC/WHO/SCOAP/AORN checklists and are they filed in the chart?
- Having the right documents in the OR or available online
- A good site marking policy
- Always having a final time-out
- Supporting a culture that permits stopping the line

PROVIDENCE
Health & Services

Preventing med admin errors

- Checking wristbands
- Use at least two identifiers
- Ask the patient to tell you identifying information
- Check identifiers against the medication orders or MAR
- Use of an integrated barcoding system

PROVIDENCE
Health & Services

Preventing med admin errors

- Nursing staff is the final line of defense
- Many admin errors turn out to be related to the five rights:
  - Right medication
  - Right dose
  - Right time
  - Right route
  - Right patient

PROVIDENCE
Health & Services

Preventing lab ID errors

- Checking wristbands
- Use at least two identifiers
- Ask the patient to tell you identifying information
- Use single pre-printed labels
- Label specimens in the presence of the patient
- Discard specimens with bad labels

PROVIDENCE
Health & Services

The problem of ambulatory

- Not a lot of wristbands or other ID technologies used in clinics
- The most common errors include med administration and mix-up of lab specimens
- Ask the patient to tell you their identifiers and to confirm lab stickers
- The five rights are your friend

The future of patient ID

- Patient photographs on wristbands
- Barcodes on everything
- Biometric markers
  - Fingerprints
  - Retina scans
- RFID chips
  - If it is good enough for Wal-Mart and the Department of Defense

PROVIDENCE
Health & Services

Conclusion

- Identification errors can have significant adverse outcomes
- Identification errors are very amenable to a systems approach for correction
- Identification errors can be a slam dunk against you in court
- You must have a process that will work consistently for everyone

PROVIDENCE
Health & Services

Further questions?

- Michael Lloyd at Providence Health and Services
- Direct line: 425-261-4657
- Fax: 425-261-4850
- E-mail: michael.lloyd@providence.org or michael.lloyd@gmail.com
- Look for the fluorescent person on a motorcycle or bicycle in Mill Creek

PROVIDENCE
Health & Services